RESOLUTION NO. 501 (California A)

Endorse Access Without Age Restriction to Over-the-Counter Oral Contraceptive Pills

Introduced by the California Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, Unintended pregnancy remains a major public health problem in the United States[1], and

WHEREAS, access and cost issues are common reasons why women either do not use contraception or have gaps in use[2], and

WHEREAS, eighty-two percent of adolescent pregnancies are unplanned, accounting for one-fifth of all unintended pregnancies in the United States[3], and

WHEREAS, teenagers experience disproportionately high rates of unintended pregnancy and face unique challenges accessing contraceptives[14], and

WHEREAS, the American Academy of Family Physicians has previously endorsed contraceptive access as an important public health measure[4], including over-the-counter (OTC) availability of oral contraceptive pills (OCPs)[5], and

WHEREAS, California approved behind-the-counter access to OCPs without an age restriction in 2015[6], and

WHEREAS, surveys indicate that most women in the United States, as well as pharmacists, look favorably upon the OTC accessing to OCPs and only a minority of women support an age restriction for OTC OCPs[7], and

WHEREAS, contraindications to oral contraceptives are more prevalent among women 35 years and older compared with younger women[8], and

WHEREAS, young adolescents do not increase their sexual risk behavior with increased access to contraception[9], and

WHEREAS, OCPs are the most commonly used hormonal contraceptive method among United States teens[10], now, therefore, be it

RESOLVED, That the American Academy of Family Physicians write to the U.S. Food and Drug Administration (FDA) to urge that all adolescents be included in the over-the-counter (OTC) oral contraceptives studies required by the FDA (e.g., label comprehension study, actual use study) to determine whether OTC access is appropriate for this population.

(Received 04/14/16)

Fiscal Impact: None

AAFP Background

Oral contraceptives have been determined to be safe and effective for use by adolescents. The AAFP has advocated on coverage of over-the-counter (OTC) contraception and insurance coverage. The AAFP sent a letter to the Centers for Medicare & Medicaid Services (CMS) asking them to review and revise the coverage of contraceptive options. The AAFP encouraged CMS to expand coverage of contraceptive options to all FDA-approved contraceptive options for men and women of reproductive age enrolled in Medicare and Medicaid. The AAFP also sent a letter to Senator Patty Murray in support of legislation on OTC access and insurance coverage regardless of prescription status.

All Medicaid programs must cover family planning services; providers and pharmacies are not permitted to charge cost-sharing for benefits. Family planning is considered a "mandatory" benefit under Medicaid, but states have discretion in identifying the specifics of inclusion in the program. Sec. 1905(a)(4)(C) of the Social Security Act provides: family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered sexually active) who are eligible under the State plan and who desire such services and supplies. Contraception is one of the primary services of family planning and many states offer broad coverage. There are a number of state Medicaid programs that currently cover OTC and/or prescriptions for emergency contraception.

When pharmaceutical companies wish to switch a drug to an over-the-counter status, the Food and Drug Administration (FDA) may ask for additional studies, such as label comprehension studies, self-selection studies, and actual use studies. Label comprehension studies are meant to ensure that consumers can understand the information on the label. Self-selection studies determine if consumers can make a correct decision about whether the medication is appropriate for them after reading the indications and warnings provided. Actual use studies determine if the medication will be used properly, safely, and effectively in the OTC setting.

The process of transferring FDA-approved prescription medications to nonprescription, over-the-counter (OTC) status is known as "Rx-to-OTC switch." This process provides consumers with convenient, cost-effective access to safe and effective medicines without the required assistance of a healthcare provider. When an ingredient is first introduced as an OTC medicine, it typically has been marketed by a manufacturer as a prescription medicine first. Then, after a sufficient amount of time has passed to enable the manufacturer to gather appropriate scientific information on the product, the manufacturer may elect to submit a new drug application, or NDA, to FDA so that it may be considered for OTC status. FDA experts review the application and determine if that product has a high enough safety profile and if labeling can be developed so that the medicine can be marketed safely and effectively as an OTC medicine.

While drug user-fee schedules do apply, each case is handled on its own merits and actually may take longer than the predetermined 10-month targeted timeframe. There are a number of reasons that the approval process may be delayed. For example, FDA may ask a manufacturer to provide additional data on the safety, effectiveness, or use of the product. The agency also may ask a manufacturer to modify a product's labeling so that it is more understandable. The important thing to remember is that each switch application is considered on its own merits.
http://www.chpa.org/SwitchFAQs.aspx(www.chpa.org)

The FDA has drafted Guidance for Industry E11 Clinical Investigation of Medicinal Products in the Pediatric Population.
http://www.fda.gov/downloads/drugs/guidancecomplianceregulatoryinformation/guidances/ucm073143.pdf(www.fda.gov)

The FDA also provides guidance to clinical investigators on including adolescents in studies. Moreover, when children are to be included as subjects in a study, the parent or guardian must provide permission in accordance with requirements for informed consent. http://www.fda.gov/RegulatoryInformation/Guidances/ucm404975.htm#children(www.fda.gov)

The following article provides a good overview on this topic. "A Difficult Proposition: Oral Contraceptives' Switch from Prescription to Over-the-counter Status." https://dash.harvard.edu/bitstream/handle/1/8965575/Ada_Dekhtyar.pdf?sequence=1(dash.harvard.edu)

Current Policy

Over-the-Counter Oral Contraceptives

Contraception Methods for Medicare Patients

Coverage, Patient Education, and Counseling for Family Planning, Contraceptive Methods, and Sterilization Procedures

Prior Congress Action

Resolution No. 503 from the 2011 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) urge the U.S. Congress and federal and state agencies to provide federal and state Medicaid coverage for all family planning drugs and supplies that are FDA-approved for sale over-the-counter, and not require a prescription for such coverage, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) urge health insurers and managed care organizations participating in Medicaid and the private insurance market to include in their insurance products coverage for all family planning drugs and supplies that are FDA-approved for sale over-the-counter, and not require a prescription for such coverage.

Please see Page 258-262 in the 2011 Transactions for details.

Resolution No. 504 from the 2011 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians support congress and federal and state agencies to enact legislation and policies that to provide federal and state Medicaid coverage for all oral contraceptive pills that are FDA-approved for sale over-the-counter, and not to require a prescription for such coverage and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) urge health insurers and managed care organizations participating in Medicaid and the private insurance market to include in their insurance products coverage for all oral contraceptive pills that are FDA-approved for sale over-the-counter, and not to require a prescription for such coverage.

Please see Pages 258-262 in the 2011 Transactions for details.

Substitute Resolution No. 503 from the 2011 COD (Substitute Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) support policies and legislation that would require public and private insurance plans to provide coverage for family planning drugs and supplies that are FDA approved, including those for sale over-the-counter.

Please see Pages 258-262 from the 2011 Transactions for details.

Please see Page 174 from the 2012 Transactions for follow-up details.

Resolution No. 504 from the 2013 COD (Referred to the BOD):

RESOLVED, That the American Academy of Family Physicians endorse the policy that oral contraceptive pills be made available over-the-counter, weighing the risks versus the benefits based on currently available data, and be it further

RESOLVED, That the American Academy of Family Physicians endorse the policy that oral contraceptive pills be included among Food and Drug Administration-approved over-the-counter contraceptive methods and supplies covered by insurers and Medicaid.

Please see Pages 310-313 in the 2013 Transactions for details.
Please see Resolution No. 504 on the AAFP website for follow-up details.

Resolution No. 505 from the 2013 COD (Referred to the BOD):

RESOLVED, That the American Academy of Family Physicians adopt policy recommending that oral contraceptives be made available for retail sale without a prescription.

Please see Pages 310-313 in the 2013 Transactions for details.
Please see Resolution No. 505 on the AAFP website for follow-up details.

Resolution No. 506 from the 2013 COD (Referred to the BOD):

RESOLVED, That the American Academy of Family Physicians write to the U.S. Food and Drug Administration (FDA) to urge that oral contraceptive pills (OCPs) be made available without a prescription and with coverage by the Centers for Medicare and Medicaid Services and commercial insurers, and be it further

References:

1. Finer LB, Zolna MR. Unintended pregnancy in the United States: incidence and disparities, 2006. Contraception. 2011;84:478-85.
2. Frost JJ, Singh S, Finer LB. U.S. women's one-year contraceptive use patterns, 2004. Perspect Sex Reprod Health 2007;39:48–55.
3. Birth Control: Choosing the method that's right for you. American Academy of Family Physicians. Updated March 2005.
4. Adolescents and long-acting reversible contraception: implants and intrauterine devices. American College of Obstetricians and Gynecologists. Committee Opinion No. 539. Obstet Gynecol. 2012;120:983–988.
5. AAFP COD 2011 – Advocacy Item 3 Adopted.
6. §1746.1 of Article 5 of Division 17 of Title 16 of the California Code of Regulations: Protocol for Pharmacists Furnishing Self-Administered Hormonal Contraception.
7. Grindlay K, Grossman D. Women's Perspectives on Age Restriction for Over-the-Counter Access to Oral Contraceptives. Grindlay K, Grossman D. J of Adol Health. 56 (2015) 38-43.
8. Grossman D, Fernandez L, Hopkins K, Amastae J, Garcia SG, Potter JE. Accuracy of self-screening for contraindications to combined oral contraceptive use. Obstet Gynecol. 2008;112(3):572-578.
9. Harper CC, Cheong M, Rocca CH, Darney PD, Raine TR. The effect of increased access to emergency contraception among young adolescents. Obstet Gynecol. 2005;106(3):483-491.
10. Upadhya, Krishna. Contraception for adolescents. Pediatrics in review [0191-9601] yr:2013 vol:34 iss:9 pg:384 -94.

11. RESOLVED, That the American Academy of Family Physicians endorse making oral contraceptive pills (OCPs) available without a prescription, with coverage by insurers and the Centers for Medicare and Medicaid Services.

Please see Pages 310-313 in the 2013 Transactions for details.
Please see Resolution No. 506 on the AAFP website for follow-up details.

Prior Board Action

Approval of a recommendation from the Commission on Health of the Public and Science that the new statement "**Over-the-Counter Oral Contraceptives** be approved as AAFP policy. B2014, July 30-August 1, pp. 10-11.

Approval of a letter of support for the Affordability is Access Act (S. 1532). BC1:12015, July 15, p. 1.

RESOLUTION NO. 502 (California B)

Medicaid Coverage of Over-the-Counter (OTC) Emergency Contraception (EC)

Introduced by the California Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, The American Academy of Family Physicians (AAFP) policy on "Reproductive Decisions" states "The American Academy of Family Physicians believes physicians should seek to … decrease the number of unwanted pregnancies," and

WHEREAS, emergency contraception (EC) can decrease unwanted pregnancies by approximately 50 percent[1], and

WHEREAS, extensive literature has established that over-the-counter (OTC) EC is safe[2], and

WHEREAS, the U.S. Food and Drug Administration (FDA) approved the sale of EC OTC in 2006 and the AAFP supported this proposal in 2003 (Resolution No. 515), and

WHEREAS, EC has a limited effectiveness window making it extremely important that patients have the ability to access this medication without delay, and

WHEREAS, numerous professional bodies, including the American Academy of Pediatrics[3], the American College of Obstetricians and Gynecologists[4], the Society of Adolescent Health and Medicine[5], the Association of Reproductive Health Professionals[6], and the American Public Health Association[7] have issued statements recognizing that EC is safe and effective for all females of reproductive age, and support OTC access without age restriction, and

WHEREAS, since becoming OTC, the cost of Plan B increased from approximately $25 to over $50, and

WHEREAS, low income women are disproportionately affected by the cost of OTC medications, and

WHEREAS, nine other states including Hawaii, Illinois, Maryland, New Jersey, New Mexico, New York, Oklahoma, Oregon, and Washington provide coverage for OTC EC through Medicaid without prescriptions, and

WHEREAS, California's Medi-Cal program, for example, covers[8] multiple other OTC medications including, but not limited to, Ibuprofen, Benadryl, Clotrimazole, Pedialyte, iron tablets, Pepto-Bismol, Hydrocortisone cream, Pepcid, Naproxen, Loratadine, prenatal vitamins, and Sudafed, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate that emergency contraception, whether over-the-counter or by prescription, be a covered benefit under all Medicaid programs for all women of reproductive age.

(Received 04/14/16)

Fiscal Impact: None

Background

The AAFP has advocated on coverage of over-the-counter (OTC) contraception and insurance coverage. The AAFP sent a letter to the Centers for Medicare & Medicaid Services (CMS) asking them to review and revise the coverage of contraceptive options. The AAFP encouraged CMS to expand coverage of contraceptive options to all FDA-approved contraceptive options for men and women of reproductive age enrolled in Medicare and Medicaid. The AAFP also sent a letter to Senator Patty Murray in support of legislation on OTC access and insurance coverage regardless of prescription status.

All Medicaid programs must cover family planning services; providers and pharmacies are not permitted to charge cost-sharing for benefits. Family planning is considered a "mandatory" benefit under Medicaid, but states have discretion in identifying the specifics of inclusion in the program. Sec. 1905(a)(4)(C) of the Social Security Act provides: family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered sexually active) who are eligible under the State plan and who desire such services and supplies. Contraception is one of the primary services of family planning and many states offer broad coverage. There are a number of state Medicaid programs that currently cover OTC and/or prescriptions for emergency contraception.

Current Policy

Over-the-Counter Oral Contraceptives

Prior Congress Action

Resolution No. 503 from the 2011 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) urge the U.S. Congress and federal and state agencies to provide federal and state Medicaid coverage for all family planning drugs and supplies that are FDA-approved for sale over-the-counter, and not require a prescription for such coverage, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) urge health insurers and managed care organizations participating in Medicaid and the private insurance market to include in their insurance products coverage for all family planning drugs and supplies that are FDA-approved for sale over-the-counter, and not require a prescription for such coverage.

Please see Page 258-262 in the 2011 Transactions for details.

Resolution No. 504 from the 2011 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians support congress and federal and state agencies to enact legislation and policies that to provide federal and state Medicaid coverage for all oral contraceptive pills that are FDA-approved for sale over-the-counter, and not to require a prescription for such coverage and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) urge health insurers and managed care organizations participating in Medicaid and the private insurance market to include in their insurance products coverage for all oral contraceptive pills that are FDA-approved for sale over-the-counter, and not to require a prescription for such coverage.

Please see Pages 258-262 in the 2011 Transactions for details.

Substitute Resolution No. 503 from the 2011 COD (Substitute Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) support policies and legislation that would require public and private insurance plans to provide coverage for family planning drugs and supplies that are FDA approved, including those for sale over-the-counter.

Please see Pages 258-262 from the 2011 Transactions for details.
Please see Page 174 from the 2012 Transactions for follow-up details.

Resolution No. 501 from the 2012 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for emergency contraception to be available over-the-counter to all women of reproductive age.

Please see Pages 375-380 in the 2012 Transactions for details.

Substitute Resolution No. 501 from the 2012 COD (Substitute Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for emergency contraception to be available without prescription to all women of reproductive age.

Please see Pages 375-380 in the 2012 Transactions for details.
Please see Page 163 in the 2013 Transactions and http://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/LT-Sebelius-OTCAccessforPlanBOneStepEmergencyContraception-120712.pdf for follow-up details.

Substitute Resolution No. 515 from the 2003 COD (Substitute Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) support the current proposal submitted to the Food and Drug Administration (FDA) to make the progesterone-only emergency contraception available over the counter, and, be it further

RESOLVED, That the AAFP recommend to the FDA appropriate labeling of progesterone-only emergency contraception that includes information on the mechanisms of action and that encourages patients to contact their primary care physician for support and/or counseling regarding use of the product, and, be it further

RESOLVED, That the American Academy of Family Physicians encourage inclusion of information on safe sexual practices and contraception in all over-the-counter emergency contraception packages.

Please see Pages 242-244 in the 2003 Transactions for details.
Please see Page 138 in the 2004 Transactions and for follow-up details.

Prior Board Action

Approval of a recommendation from the Commission on Health of the Public and Science that the new statement "Over-the-Counter Oral Contraceptives" be approved as AAFP policy.

B2014, July 30-August 1, pp. 10-11.

Approval of a letter of support for the Affordability is Access Act (S. 1532).

BC1:12015, July 15, p. 1.

References:

1. Trussell J, Ellertson C, von Hertzen H, Bigrigg A, Webb A, Evans M, Ferden S. Leadbetter C. Estimating the effectiveness of emergency contraceptive pills. Contraception. 2003;67:259- 65.
2. Grimes DA, Raymond EG, Scott Jones B. Emergency contraception over-the-counter: the medical and legal imperatives. Obstet Gynecol. 2001;98:151-5.
3. American Academy of Pediatrics Committee on Adolescence. Policy Statement: Emergency Contraception. Pediatrics. 2012;130:1174–1182. www.pediatrics.org/cgi/doi/10.1542/peds.2012-2962. doi:10.1542/peds.2012-2962
4. ACOG Committee Opinion http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Access-to-Emergency-Contraception.
5. American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and Society of Adolescent Health and Medicine. (2011) Medical Groups Denounce HHS Decision on Access to Emergency Contraception: Move Defies Strong Evidence that Emergency Contraception is a Safe, Effective Tool to Prevent Unintended Pregnancy. [Press Release]. http://www.acog.org/~/media/News%20Releases/20111207Release.ashx.
6. Association of Reproductive Health Professionals. Position Statement on Contraception/Emergency Contraception. Approved by ARHP's Policy Committee June 2012, and approved by ARHP's Board of Directors June 30, 2012. https://www.arhp.org/about-us/position-statements#2.
7. American Public Health Association. Support of Public Education about Emergency Contraception and Reduction or Elimination of Barriers to Access. Policy Date: November 18, 2003. Policy Number: 200315. http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/24/15/29/support-of-public-ed-about-emergency-contraception-and-elimination-of-barriers-to-access.
8. http://www.dhcs.ca.gov/services/Pages/ff.html.

RESOLUTION NO. 503 (New York A)

Increase Access to Comprehensive Reproductive Health Care Services for Incarcerated Women

Introduced by the New York State Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, Reproductive health care offered in correctional settings is often lacking, inadequate, and/or inappropriate[1], and

WHEREAS, the number of women in prison or jails has tripled in the past decade[2], with over one million women incarcerated, under parole, or on probation, and

WHEREAS, women are the fastest growing incarcerated population[3], and

WHEREAS, the majority of incarcerated women are of reproductive age[4], and

WHEREAS, black women are incarcerated at nearly three times the rate of white women, and

WHEREAS, Hispanic women are incarcerated at 1.6 times the rate of white women[5],

WHEREAS, these groups already have worse health and access to health care as compared to their white counterparts, and

WHEREAS, approximately 5-6% of women entering correctional facilities are pregnant when they do so[6,7], and

WHEREAS, incarcerated women usually have had less and worse access to medical care in the community, and

WHEREAS, incarceration can be an opportunity to provide comprehensive reproductive health to those who desire it[8], and

WHEREAS, contraception and other reproductive health care services are not being routinely provided, but it is possible to do so[9], and

WHEREAS, some women are open to receiving it during incarceration[10], and

WHEREAS, access to a proper prenatal diet, fresh air, exercise, sanitary conditions, and appropriate work assignments all impact a woman's ability to care for herself and her pregnancy[11], and

WHEREAS, incarcerated women are often given little, none, or inappropriate prenatal care and nutrition[12], and

WHEREAS, many women who are pregnant during the time of incarceration are shackled during transport, labor, and delivery, and

WHEREAS, only 18 states have specific laws against the practice of shackling[13], and

WHEREAS, the American College of Obstetricians and Gynecologists has stated that medical care for incarcerated women and adolescents should be no different from care for women and adolescent females who are not incarcerated, and

WHEREAS, increased attention should be given to comorbidities[14] and increased risk of mental illness[15], and

WHEREAS, standards of care have been created by the National Commission on Correctional Health Care (NCCHC)[16] and the American Public Health Association (APHA)[17], but there is no mandatory accreditation[18], and no means to enforce use of these standards, and thus no regulation of care, and

WHEREAS, the NCCHC recommends that all women entering facilities should be offered a screening for gynecological issues or infections, a pelvic examination and Pap smear, substance withdrawal management, contraception, and if pregnant, counseling on her full options to carry to term, elect adoption, or elect abortion, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate that comprehensive and appropriate health care be provided to incarcerated women in federal detention facilities including but not limited to reproductive health.

(Received 0730/16)

Fiscal Impact: None

Background

Incarcerated women often represent those who are from economically, educationally, socially, and emotionally disadvantaged environments; a disproportionate number have acute and chronic illnesses, substance abuse problems, and undetected health issues, including reproductive health needs.
http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-Health-Care-for-Incarcerated-Women-and-Adolescent-Females

In 2004, a Bureau of Justice Statistics survey found that 3% of women in federal prisons and 4% of those in state prisons were pregnant upon arrival. The statistics on pregnancy in local jails based on a 2002 survey found that 5% of women entered local jails were pregnant. At those rates, approximately 9,430 pregnant women are incarcerated annually. Also, the sexually transmitted infection rate for incarcerated women is an area of concern. For example, 27% of incarcerated women had chlamydia and 8% had gonorrhea, compared with rates of 0.46% and 0.13% in the general population. Mental health conditions and substance abuse issues often put women at risk for being incarcerated. A high percentage (85-90%) of inmates also indicate histories of exposure to violence and experienced sexual abuse.

Recommendations for care include comprehensive screening and evaluation upon entry, access to pregnancy care, promotion of preventive care, supportive aging care, and mental health care access. Health care standards for jails, prisons, and juvenile facilities have been developed by the National Commission on Correctional Health Care, the American Correctional Association, and the American Public Health Association. The federal government does not require correctional health facilities to obtain accreditation, and there

is no organization to which all facilities are accountable. Several organizations accredit prisons, but their standards serve as voluntary guidelines.

Health care varies based on whether an inmate is housed in a federal, state, or local facility. Financing of federal correctional facilities, including health care, depends on appropriations that compete with other priorities. A significant majority of inmates are housed in state facilities (87%) where both funding and standards may differ within each jurisdiction.

In general, Medicaid funding cannot be used for care for adults and adolescents in secure confinement because the federal inmate exclusion policy. Also, individuals may not purchase coverage through the Marketplace while serving a term in prison or jail. http://kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/

According to a 2016 Department of Justice Inspector General's Report, the Federal Bureau of Prisons (BOP) relies on outside medical services to provide care for inmates that cannot be provided by institution staff. From fiscal years 2010 to 2014, BOP spending for outside medical services increased 24%, from $263 million to $327 million, while BOP's overall budget increased at less than half that rate, 11%, from $6.2 billion to $6.9 billion. The BOP is the only federal agency that pays for medical care that is not covered under a statute or regulation under which the government sets the agency's reimbursement rates, usually at the Medicare rate. The agency solicits and awards a comprehensive medical services contract for each BOP institution to obtain outside medical services.

Several reports indicate that waste, fraud, and health care abuse are associated with private contracts, and that companies do not have the same level of accountability as governmental entities. In addition, prisoners may be charged co-pays for health care services, which may create health care barriers. Among inmates with chronic medical problems, a 2009 study revealed that many did not receive a medical exam while incarcerated, including 68% of local jail inmates, 20% of state prison inmates and 14% of federal prison inmates. A1976 Supreme Court case (*Estelle v. Gamble),* established that not providing adequate medical care to prisoners was a violation of the Constitution's Eighth Amendment against cruel and unusual punishment. Still, courts have allowed prisons to attempt to recoup some of the costs of treating inmates by charging them for their care.

According to the Bureau of Justice Statistics, the number of incarcerated women increased by more than 700%, rising from a total of 26,378 in 1980 to 215,332 in 2014. Federal Bureau of Prison's June 2016 data indicates that 13,009 female prisoners are housed within federal facilities, 6.7% of its prison population.

The BOP policy provides female inmates with medical and social services related to pregnancy, birth control, child placement, and abortion. BOP also provides each inmate with a complete medical exam within 30 days of admission and adheres to ACOG's standards for yearly exams.

Women housed in some facilities may have access to a community residential program called Mothers and Infants Nurturing Together (MINT) for women who are pregnant at the time of commitment. The MINT program is based in a residential reentry center and promotes bonding and enhanced parenting skills for low-risk female inmates who are pregnant. Inmates in this program participate in pre- and post-natal classes on such topics as childbirth, parenting, and coping skills. In addition to services specifically related to parenting, MINT sites also offer chemical dependency treatment, physical and sexual abuse counseling, budgeting classes, and vocational and educational programs.

In accordance with Federal law, the BOP may not use appropriated funds to require any person to perform or facilitate the performance of an abortion. BOP funds are used to pay for abortion services only when the life of the mother would be endangered if the fetus is carried to term or in the case of rape. In all other cases, non-BOP funds must be obtained to pay for an abortion.
https://www.bop.gov/inmates/custody_and_care/female_offenders.jsp

Congressional Action

On August 4, 2015, the Senate Homeland Security and Governmental Affairs Committee hearing on "Oversight of the Bureau of Prisons: First-Hand Accounts of Challenges Facing the Federal Prison System" to examine conditions, including access to mental health care.
http://www.hsgac.senate.gov/hearings/oversight-of-the-bureau-of-prisons-first-hand-accounts-of-challenges-facing-the-federal-prison-system

Currently, members of Congress are considering several prison reform proposals to reduce populations, lower costs, and streamline sentencing guidelines. The major bills under consideration do not include new accountability standards for reproductive health care for incarcerated women. It is unclear if sentencing reform will be enacted by the current Congress.

The AAFP has not been actively engaged in the criminal justice debate, but did write a letter to the Senate Committee on Health, Education, Labor, and Pensions regarding the Mental Health Reform Act of 2016 (S. 2680). The AAFP applauded the bill's emphasis on the mental health care needs of vulnerable populations, including the incarcerated. The committee approved S. 2680 on March 16, 2016. It has yet to come up for a vote within the full U.S. Senate.

Medicaid Financing, Prevention, and Recidivism

A 2014 report from the Sentencing Project indicates that *Affordable Care Act's* Medicaid expansion policy represents a tremendous opportunity to help disadvantaged women lower their risk of being incarcerated through the policies that access to mental health and substance use treatment. 69% of women admitted to local jails met the criteria for substance dependence or abuse (not including tobacco use); dependence was diagnosed more commonly among women than among men. Rates of mental health problems among women inmates ranged from 61% in federal prisons to 75% in local jails.

Helping ex-offenders access social services and health care are also associated with reduced rates of recidivism, particularly among individuals with mental health and substance abuse disorders. For example, a 2013 study show that in Michigan, rates of recidivism fell following implementation of an initiative that linked newly released prisoners to a medical home in the community and helped them access needed medications and primary and specialty care, and assisted them in obtaining their medical records upon release.

Current Policy

Fairness in Federal Programs for All U.S. Citizens

Reproductive Health Services

Health Care

Women Health Care

Prior Congress Actions

Resolution No. 511 from the 2013 COD (Referred to the Board of Directors):

RESOLVED, That the American of Family Physicians advocate for the continuation of Medicaid coverage for adolescents when they are incarcerated, thereby securing their health status and ability to access care, and be it further

RESOLVED, That the American of Family Physicians dialogue with the proper stakeholders in order to effect change within the federal Medicaid system to assist states to cover adolescents when they are incarcerated.

Please see Pages 306-307 in the 2013 Transactions for details.

Please see Resolution No. 511 on the AAFP website for follow-up details.

Prior Board Actions

None

References:

1. Angela Y. Davis and Cassandra Shaylor, "Race, Gender, and the Prison Industrial Complex: California and Beyond," *Meridians* 2, no. 1 (2001): 1–25.
2. Lauren E. Glaze, Danielle Kaeble, "Correctional Population in the United States, 2013," *Bureau of Justice Statistics Bulletin* (December 2014). Accessed March 1,2016, http://www.bjs.gov/content/pub/pdf/cpus13.pdf
3. "Caught in the Net."
4. "Committee Opinion No. 535: Reproductive Health Care for Incarcerated Women and Adolescent Females," *Obstetrics & Gynecology*, August 2012, 425–29, doi:10.1097/AOG.0b013e318268052d.
5. "Incarcerated Women Fact Sheet, "*The Sentencing Project* (September 2012). Accessed March 1, 2016, http://www.sentencingproject.org/doc/publications/cc_Incarcerated_Women_Factsheet_Sep24sp.pdf
6. "Incarcerated Women Fact Sheet, "*The Sentencing Project* (September 2012). Accessed March 1, 2016, http://www.sentencingproject.org/doc/publications/cc_Incarcerated_Women_Factsheet_Sep24sp.pdf
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10. Dana Schonberg et al., "What Women Want: A Qualitative Study of Contraception in Jail," *American Journal of Public Health* 105, no. 11 (September 17, 2015): 2269–74, doi:10.2105/AJPH.2015.302765.
11. Ferszt and Clarke, "Health Care of Pregnant Women in U.S. State Prisons."
12. Davis and Shaylor, "Race, Gender, and the Prison Industrial Complex."
13. "The Shackling of Pregnant Women & Girls in U.S. Prisons, Jails & Youth Detention Centers," *American Civil Liberties Union*, accessed March 1, 2016, https://www.aclu.org/files/assets/anti-shackling_briefing_paper_stand_alone.pdf
14. lack of prenatal care, poor nutrition, domestic violence, drug and alcohol use, higher STI rates, HIV, Hepatitis C, human papillomavirus, homelessness, and physical and/or sexual abuse
15. "Committee Opinion No. 535: Reproductive Health Care for Incarcerated Women and Adolescent Females," *Obstetrics & Gynecology*, August 2012, 425–29, doi:10.1097/AOG.0b013e318268052d.

16. “Women’s Health Care in Correctional Settings | National Commission on Correctional Health Care,” accessed March 1, 2016, http://www.ncchc.org/women%E2%80%99s-health-care.
17. “Correctional Health Care Standards and Accreditation,” accessed March 1, 2016, http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/02/12/07/correctional-health-care-standards-and-accreditation.
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RESOLUTION NO. 504 (Oregon E)

Medicare Drug Negotiation Powers

Introduced by the Oregon Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, Medicare Part D plans pay for some outpatient prescription drugs and are operated by private insurance companies with oversight by Medicare, and

WHEREAS, Medicare Part D cost $67.67 billion[1] in 2014, $88 billion in 2016[2], and is projected to double in cost between 2012 and 2022 in part due to an aging population and in part due to improving coverage[3], and

WHEREAS, Medicare Part D is currently prohibited from negotiating drug prices using the leverage of 39.1 million enrollee's[4], and

WHEREAS, the Veterans Benefits Administration (VBA) and Medicaid are allowed to negotiate drug prices and Medicare Part D pays on average 73% more than Medicaid and 80% more than VBA for brand-name drugs"[5], and

WHEREAS, 58% of Medicare Part D expenditures went to brand-name drugs in 2011[6], and

WHEREAS, Medicare Part D would save $15.2 billion to $16 billion a year if it could secure the same prices that Medicaid or VBA, respectively, receives on the same brand-name drugs[7], and

WHEREAS, a common argument against allowing price negotiation is the so-called "innovation crisis" in which profits become so low that innovation halts, and

WHEREAS, the cost of new drug discovery is often cited at $1.3 billion, however, after breaking down the accounting, the actual cost is around $60 million[8], and

WHEREAS, pharmaceutical companies devote 1.3% of their revenues to discovering new medicines[9] while 25% is spent on marketing and promotion[10], meaning they spend 19 times more money on marketing than research[11], and

WHEREAS, Minnesota Senator, Amy Klobuchar, has introduced a bill entitled "The Medicare Prescription Drug Price Negotiation Act" in 2013 and 2015[12] intending to allow Medicare Part D to begin negotiating drug prices, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians support allowing Medicare Part D to negotiate for drug prices.

Received 06/23/16)

Fiscal Impact: None

Background

The U.S. Congress added the Medicare Prescription Drug Benefit ("Medicare Part D") to Medicare in 2003. Part D went into effect on January 1, 2006. Under the Part D benefit, Medicare beneficiaries may enroll in a prescription drug plan (PDP)—an insurance product that pays most of the cost of covered prescription drugs. Enrollment in Part D is voluntary, and involves out-of-pocket costs to the beneficiary: an annual premium, as well as coinsurance, depending on the type of drug and the price.

As enacted, Part D contains a provision known as the "non-interference clause," which provides: "In order to promote competition under [Part D], the Secretary (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs."[1]

Repeal of the non-interference clause has been a Democratic priority since enactment of the Medicare Part D benefit in 2003. Legislation introduced by U.S. Senator Amy Klobuchar (D-MN) would strike the non-interference clause and replace it with language that provides: "the Secretary shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered part D drugs for covered part D eligible individuals who are enrolled under a prescription drug plan or under an MA-PD plan."

The impact of this language on cost savings is a matter of some debate. The Congressional Budget Office (CBO) has stated that "although cost savings might be possible in selective instances, the impact on Medicare's overall drug spending would likely be limited."[2] However, removal of the non-interference clause remains—both symbolically and also in practice—a threat to the drug industry and one that it has fought mightily to prevent. Although the non-interference clause is also generally protected by Republican lawmakers, both of the 2016 major party's' presidential candidates support its repeal.

Another related proposal that is embraced by the Obama Administration, Hillary Clinton, and many Democratic lawmakers is the *Medicare Drug Savings Act*, HR 2005, sponsored by Rep. Kathy Castor (D-FL) and S 1083, sponsored by Sen. Bill Nelson (D-FL). That bill would require the drug makers, as a condition of participation in Part D, to enter into rebate agreements under which the manufacturer would provide the Secretary rebates that resemble those in the Medicaid program (Congress did not adopt a Medicaid-like rebate provision during enactment of Part D in 2003). This bill is similarly strongly opposed by the pharmaceutical industry, but has been found to provide so called "scorable savings" by CBO. This provision is included in many budget blueprints, including several of President Obama's budget proposals to Congress, and the 2010 final report of the National Commission on Fiscal Responsibility and Reform (also known as the Simpson-Bowles Commission).

1 See Social Security Act, Section 1860D-11(i).
2. https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/drugpricenegotiation.pdf

Current Policy

Collective Negotiation

Direct Contracting with Businesses by Family Physicians (Discussion Paper)

Patient-Centered Formularies

Prior Congress Action

Resolution No. 313 from the 2015 COD (Substitute Adopted):

RESOLVED, That the American Academy of Family Physicians advocate for with the Centers for Medicare and Medicaid Services to modify the Medicare Part D plans, so patients have adequate and affordable choices for their physicians to treat their chronic conditions, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for the Centers for Medicare and Medicaid Services to have Medicare Part D plans cover a broader choice of medications with less paperwork and fewer hindrances that can delay the provision of timely, quality medical care.

Please see Page 294-295 in the 2015 Transactions for details.
Please see Substitute Resolution No. 313 on the AAFP website for follow-up details.

Prior Board Action

Approval of a letter to CMS on the 2015 proposed Medicare Advantage (Part C) and Prescription Drug Plan (Part D).

BC1:12014, March 13, p. 4.

Approval of a letter to CMS in response to the draft 2016 Part C and Part D call letter.

BC1:12015, March 11, p. 2.

References:

1. http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/
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7. http://freepdfhosting.com/ff84833f9f.pdf
8. http://www.bmj.com/content/345/bmj.e4348
9. http://www.bmj.com.liboff.ohsu.edu/content/331/7522/958?ijkey=c7093b94639105aa38c03170796e51ce92202d78&keytype2=tf_ipsecsha
10. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174966/
11. http://www.bmj.com/content/345/bmj.e4348

RESOLUTION NO. 505 (Illinois A)

Medicare Prescription Drug Price Savings

Introduced by the Illinois Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, The Medicare Modernization Act of 2003 prohibits Medicare from directly negotiating drug prices with manufacturers[1] and rescinded rebates for "dually eligible" (Medicare and Medicaid) patients[2], and

WHEREAS, Medicare Part D plans pay an average of 73% more than Medicaid and 80% more than the Veterans Health Administration (VHA) for brand name drugs[1], and

WHEREAS, true out-of-pocket medical costs are rising (including premiums, deductibles, and co-insurance), and

WHEREAS, seniors spend an average of 37% of their social security check on medical care[3], and

WHEREAS, among Medicare Part D recipients, studies have shown significant rates of cost related drug non-adherence, resulting in increased morbidity and mortality[4,5], and

WHEREAS, the American Academy of Family Physicians has expressed concerns to the Centers for Medicare and Medicaid Services regarding increasing Medicare Part D drug prices, increasing co-payments and decreasing drug adherence, and the impact on value-based physician payments[6], and

WHEREAS, allowing Medicare to directly negotiate with drug manufacturers and restoring drug rebates for low income Medicare recipients could save Medicare nearly $16 billion dollars annually[1], and

WHEREAS, prescription drugs in Canada are equivalently regulated and often cheaper, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate for strengthening Medicare by supporting legislation that allows Medicare to negotiate drug prices, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for strengthening Medicare by supporting legislation that allows Medicare to manage formularies, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for strengthening Medicare by supporting legislation that allows Medicare to restore drug rebates for low income beneficiaries, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for strengthening Medicare by supporting legislation that allows Medicare to allow drug importation/re-importation from Canada.

(Received 08/01/16)

Fiscal Impact: None

Background

Congress added the Medicare Prescription Drug Benefit ("Medicare Part D") to Medicare in 2003. Part D went into effect on January 1, 2006. Under the Part D benefit, Medicare beneficiaries may enroll in a prescription drug plan (PDP)—an insurance product that pays most of the cost of covered prescription drugs. Enrollment in Part D is voluntary, and involves out-of-pocket costs to the beneficiary: an annual premium, as well as coinsurance, depending on the type of drug and the price.

Negotiation of Drug Prices and Formularies

Part D as enacted in the *Social Security Act*, Section 1860D-11(i) is constrained by a provision known as the "non-interference clause," which provides: "In order to promote competition under [Part D], the Secretary (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs."

Repeal of the non-interference clause has been a Democratic priority since enactment of the Medicare Part D benefit in 2003. Legislation introduced by U.S. Senator Amy Klobuchar (D-MN) would strike the non-interference clause and replace it with language that provides: "the Secretary shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered part D drugs for covered part D eligible individuals who are enrolled under a prescription drug plan or under an MA-PD plan."

The impact of this language on cost savings is a matter of some debate. The Congressional Budget Office (CBO) has stated that "although cost savings might be possible in selective instances, the impact on Medicare's overall drug spending would likely be limited." However, removal of the non-interference clause remains—both symbolically and also in practice—a threat to the drug industry and one that it has fought mightily to prevent. Although the non-interference clause is also generally protected by Republican lawmakers, both of the 2016 major party's' presidential candidates support its repeal.

Rebates

Prior to 2006, beneficiaries who were enrolled in both Medicare and Medicaid (so-called "dual eligibles") received their prescription drug coverage through Medicaid, which requires drug manufacturers to pay a substantial rebate on the sales of the drugs to the Medicaid beneficiary.

The establishment of Part D shifted dual eligibles' prescription drug coverage from Medicaid into Part D. (Duals were enrolled automatically in the low-income subsidy (LIS) program, which generally covers the premiums and other cost sharing borne by Part D beneficiaries). However, Congress did not import the rebate mechanism from Medicaid into Medicare Part D, allowing the drug makers to keep more taxpayer dollars under Medicare than they had under Medicaid.

A proposal to fix this that is embraced by the Obama Administration, Hillary Clinton, and many Democratic lawmakers is the *Medicare Drug Savings Act*, HR 2005, sponsored by Rep. Kathy Castor (D-FL) and S 1083, sponsored by Sen. Bill Nelson (D-FL). That bill would require the drug makers, as a condition of participation in Part D, to enter into rebate agreements under which the manufacturer would provide the Secretary rebates that resemble those in the Medicaid program (Congress did not adopt a Medicaid-like rebate provision during enactment of Part D in 2003). This bill is similarly strongly opposed by the pharmaceutical industry, but has been found to provide so called "scorable savings" by CBO. This provision is included in many budget blueprints, including several of President Obama's budget proposals to Congress, and the 2010 final report of the National Commission on Fiscal Responsibility and Reform (also known as the Simpson-Bowles Commission).

Importation

There is currently pending in both House and Senate a bipartisan bill that would allow Americans to import prescription drugs from Canada. The bill is the *Safe and Affordable Drugs from Canada Act*, sponsored by Sens. Amy Klobuchar (D-MN) and John McCain (R-AZ), and Reps. Chellie Pingree (D-ME) and Dana Rohrbacher (R-CA). According to a media release accompanying the introduction of the bill dated May 5, 2015: "Under the legislation, imported prescription drugs would have to be purchased from an approved Canadian pharmacy and dispensed by a licensed pharmacist. Drugs imported under this bill would be the same dosage, form, and potency as drugs in the U.S., but at a significant savings to U.S. consumers." In addition, "the U.S. spent a total of more than $271 billion on prescription drugs in 2013 alone, and we spend an average of almost $1,000 per person per year on pharmaceuticals—roughly 40 percent more than the next highest country." Specifically, the bill provides: "Notwithstanding any other provision of this Act, not later than 180 days after the date of enactment of this section, the Secretary shall promulgate regulations permitting individuals to safely import into the United States a [covered] prescription drug." CBO has reported that "permitting the importation of foreign-distributed prescription drugs would produce at most a modest reduction in prescription drug spending in the United States."

Current Policy

Collective Negotiation

Direct Contracting with Businesses by Family Physicians (Discussion Paper)

Patient-Centered Formularies

Prior Congress Actions

Substitute Resolution No. 313 from the 2015 COD (Adopted):

RESOLVED, That the AAFP advocate for with the CMS to modify the Medicare Part D plans, so patients have adequate and affordable choices for their physicians to treat their chronic conditions, and be it further

RESOLVED, That the AAFP advocate for the Centers for Medicare and Medicaid Services to have Medicare Part D plans cover a broader choice of medications with less paperwork and fewer hindrances that can delay the provision of timely, quality medical care.

Please see Pages 294-295 in the 2015 Transactions for details.

Please see Resolution No. 313 on the AAFP website for follow-up details.

Prior Board Actions

Approval of a letter to CMS in support of their proposed rule that imposes the medical loss ratio requirement onto Medicare Advantage and Prescription Drug Plans, Parts C and D respectively.
BC1:12013, April 10, p. 2.

Approval of a letter to CMS on the 2015 proposed Medicare Advantage (Part C) and Prescription Drug Plan (Part D).
BC1:12014, March 13, p. 4.

Approval of a recommended letter to CMS advocating for patients to have a broader choice of adequate and affordable prescription drugs while reducing administrative burden for physicians.
BC1:12016 April 6, p. 2.

Approval of a letter to CMS advocating to educate physicians about Medicare Advantage Plans and the cost-shifting that may affect patients in response to 2015 COD Resolution No. 305, "Medicare Advantage Plans."
BC1:12016 April 20, p. 1.

References:

1. Gagnon MA, Wolfe S. Mirror, Mirror on the Wall: Medicare Part D pays needlessly high brand-name drug prices compared with other OECD countries and with U.S. government programs. Policy Brief from the Carleton University School of Public Policy and Administration and Public Citizen. Jul 23, 2015.

2. Sanders S, Veghte B. A Winning Strategy for Medicare Savings: Better Prices on Prescription Drugs. Policy Brief from the Medicare Rights Center and Social Security Works. Jul 2014.

3. Strengthen Social Security… Don't Cut It. Position Paper from Strengthen Social Security Coalition. Jan 22, 2014.

4. Yang Y, Thumula V, Pace PF, Bahanan BF, Wilkin NE, Lobb WB. Medication Nonadherence and the Risks of Hospitalization, Emergency Department Visits, and Death Among Medicare Part D Enrollees With Diabetes. *Drug Benefit Trends*. 2009; 21(12).

5. Williams J, Steers WN, Ettner SL, Mangione CM, Duru OK. Cost-related nonadherence by medication type among Medicare Part D beneficiaries with diabetes. *Med Care.* 2013 Feb;51(2):193-8.

6. American Academy of Family Physicians. Letter to Andy Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services. Nov 9, 2015.

RESOLUTION NO. 506 (New York D)

Medicare Drug Price Savings

Introduced by the New York State Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, The Medicare Modernization Act of 2003 prohibits Medicare from directly negotiating drug prices with manufacturers[1], and rescinded rebates for "dually eligible" (Medicare and Medicaid) patients[2], and

WHEREAS, Medicare Part D plans pay an average of 73% more than Medicaid and 80% more than the Veterans Health Administration for brand name drugs[1], and shift the costs onto their members[2], and

WHEREAS, out of pocket medical costs are rising (including premiums, deductibles, and co-insurance), and

WHEREAS, seniors spend an average of 37% of their social security check on medical costs[3]; and

WHEREAS, among Medicare Part D recipients, studies have shown significant rates of cost related medication non-adherence, resulting in increased morbidity and mortality[4,5], and

WHEREAS, the American Academy of Family Physicians has expressed concerns to the Centers for Medicare and Medicaid Services regarding increasing Medicare Part D drug prices, increasing co-payments and decreasing medication adherence, and the impact on value-based physician payments[6], and

WHEREAS, allowing Medicare to directly negotiate with drug manufacturers and restoring drug rebates for low income Medicare recipients could save Medicare nearly $16 billion dollars annually, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate for seniors and the disabled by supporting legislation that empowers Medicare to directly negotiate drug prices with manufacturers with the intent of producing lower drug prices for patients.

(Received 07/30/16)

Fiscal Impact: None

Background

The U.S. Congress added the Medicare Prescription Drug Benefit ("Medicare Part D") to Medicare in 2003. Part D went into effect on January 1, 2006. Under the Part D benefit, Medicare beneficiaries may enroll in a prescription drug plan (PDP)—an insurance product that pays most of the cost of covered prescription drugs. Enrollment in Part D is voluntary, and involves out-of-pocket costs to the beneficiary: an annual premium, as well as coinsurance, depending on the type of drug and the price.

As enacted, Part D contains a provision known as the "non-interference clause," which provides: "In order to promote competition under [Part D], the Secretary (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs."[1]

Repeal of the non-interference clause has been a Democratic priority since enactment of the Medicare Part D benefit in 2003. Legislation introduced by U.S. Senator Amy Klobuchar (D-MN) would strike the non-interference clause and replace it with language that provides: "the Secretary shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered part D drugs for covered part D eligible individuals who are enrolled under a prescription drug plan or under an MA-PD plan."

The impact of this language on cost savings is a matter of some debate. The Congressional Budget Office (CBO) has stated that "although cost savings might be possible in selective instances, the impact on Medicare's overall drug spending would likely be limited."[2] However, removal of the non-interference clause remains—both symbolically and also in practice—a threat to the drug industry and one that it has fought mightily to prevent. Although the non-interference clause is also generally protected by Republican lawmakers, both of the 2016 major party's' presidential candidates support its repeal.

Another related proposal that is embraced by the Obama Administration, Hillary Clinton, and many Democratic lawmakers is the *Medicare Drug Savings Act*, HR 2005, sponsored by Rep. Kathy Castor (D-FL) and S 1083, sponsored by Sen. Bill Nelson (D-FL). That bill would require the drug makers, as a condition of participation in Part D, to enter into rebate agreements under which the manufacturer would provide the Secretary rebates that resemble those in the Medicaid program (Congress did not adopt a Medicaid-like rebate provision during enactment of Part D in 2003). This bill is similarly strongly opposed by the pharmaceutical industry, but has been found to provide so called "scorable savings" by CBO. This provision is included in many budget blueprints, including several of President Obama's budget proposals to Congress, and the 2010 final report of the National Commission on Fiscal Responsibility and Reform (also known as the Simpson-Bowles Commission).

1 See Social Security Act, Section 1860D-11(i).
2. https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/drugpricenegotiation.pdf

Current Policy

Collective Negotiation

Direct Contracting with Businesses by Family Physicians (Discussion Paper)

Patient-Centered Formularies

Prior Congress Action

Resolution No. 313 from the 2015 COD (Substitute Adopted):

RESOLVED, That the American Academy of Family Physicians advocate for with the Centers for Medicare and Medicaid Services to modify the Medicare Part D plans, so patients have adequate and affordable choices for their physicians to treat their chronic conditions, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for the Centers for Medicare and Medicaid Services to have Medicare Part D plans cover a broader choice of medications with less paperwork and fewer hindrances that can delay the provision of timely, quality medical care.

Please see Page 294-295 in the 2015 Transactions for details.
Please see Substitute Resolution No. 313 on the AAFP website for follow-up details.

Prior Board Action

Approval of a letter to CMS on the 2015 proposed Medicare Advantage (Part C) and Prescription Drug Plan (Part D).
BC1:12014, March 13, p. 4.

Approval of a letter to CMS in response to the draft 2016 Part C and Part D call letter.
BC1:12015, March 11, p. 2.

References:

1. Gagnon MA, Wolfe S. Mirror, Mirror on the Wall: Medicare Part D pays needlessly high brand-name drug prices compared with other OECD countries and with U.S. government programs. Policy Brief from the Carleton University School of Public Policy and Administration and Public Citizen. Jul 23, 2015.
2. Sanders S, Veghte B. A Winning Strategy for Medicare Savings: Better Prices on Prescription Drugs. Policy Brief from the Medicare Rights Center and Social Security Works. Jul 2014.
3. Strengthen Social Security… Don't Cut It. Position Paper from Strengthen Social Security Coalition. Jan 22, 2014.
4. Yang Y, Thumula V, Pace PF, Bahanan BF, Wilkin NE, Lobb WB. Medication Nonadherence and the Risks of Hospitalization, Emergency Department Visits, and Death Among Medicare Part D Enrollees With Diabetes. Drug Benefit Trends. 2009; 21(12).
5. Williams J, Steers WN, Ettner SL, Mangione CM, Duru OK. Cost-related nonadherence by medication type among Medicare Part D beneficiaries with diabetes. Med Care. 2013 Feb;51(2):193-8.
6. American Academy of Family Physicians. Letter to Andy Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services. Nov 9, 2015.

RESOLUTION NO. 507 (Co-Sponsored J)

Remove the Fifth Vital Sign (The Pain Score)

Introduced by the Georgia and Massachusetts Chapters

Referred to the Reference Committee on Advocacy

WHEREAS, According to the Centers for Disease Control and Prevention, opioid prescriptions have quadrupled, and

WHEREAS, over 165,000 people have died from prescription opioids since 1999, and

WHEREAS, the U.S. Food and Drug Administration now is recommending mandatory training for physicians who prescribe opioids, and

WHEREAS, the push by the Federation of State Medical Boards encouraged physicians to treat the fifth vital sign, the pain score, by prescribing more narcotics, and

WHEREAS, physicians who have resisted prescribing more narcotics have seen patient satisfaction scores drop, and

WHEREAS, the annual number of deaths attributed to prescription pain killers is over 14,000 per year, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians work to bring to the attention of the legislature, the Centers for Disease Control and Prevention, the U.S. Food and Drug Administration, the America's Health Insurance Plans, accrediting organizations (e.g., National Committee on Quality Assurance, The Joint Commission, Utilization Review Accreditation Commission) as well as the Federation of State Medical Boards, the need to do away with the "fifth vital sign" (the pain score) as a determination of patient care.

(Received 6/30/16)

Fiscal Impact: None

Background

In 1999 in an effort to improve pain management, the Veterans Health Administration launched the "Pain as the 5th Vital Sign" initiative, requiring a pain intensity rating (0 to 10) at all clinical encounters. However, the Journal of General Internal Medicine in June 2006 published a study which concluded that measuring pain did not increase the quality of pain management. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924634/

On July 6, 2016, U.S. Health and Human Services (HHS) Secretary Sylvia Burwell announced several initiatives to combat the nation's opioid epidemic including the elimination of any incentive as part of patient experience surveys for physicians to prescribe opioids. http://www.hhs.gov/about/news/2016/07/06/hhs-announces-new-actions-combat-opioid-epidemic.html

The Hospital Consumer Assessment of Healthcare Providers and Systems or HCAHPS survey is a means to assess patient satisfaction and helps hospitals and individual providers measure how patients perceived the quality of their healthcare. Many clinicians report feeling pressure to overprescribe opioids because scores on the HCAHPS survey pain management questions are tied to Medicare payments to hospitals. But those payments currently have a very limited connection to the pain management questions on the HCAHPS survey. In order to mitigate even the perception that there is financial pressure to overprescribe opioids, the Centers for Medicare and Medicaid Services (CMS) is proposing to remove the HCAHPS survey pain management questions from the hospital payment scoring calculation. This means that hospitals would continue to use the questions to survey patients about their in-patient pain management experience, but these questions would not affect the level of payment hospitals receive. http://patientengagementhit.com/news/hhs-proposes-patient-satisfaction-changes-for-pain-management

Current Policy

Pain Management and Opioid Abuse: A Public Health Concern

Prior Congress Actions

Resolution No. 605 from the 2013 COD (Adopted):

RESOLVED, That the American Academy of Family Physicians oppose legislation or executive action that would require mandatory education of family physicians as a condition for prescribing specific drugs, diagnosing specific diseases, or treating specific patient populations, behaviors or illnesses above and beyond that mandated by physician specialty boards.

Please see Pages 361-362 in the 2013 Transactions for details.
Please see Resolution No. 605 on the AAFP website for follow-up details.

Prior Board Actions

Approval of a recommendation from the Commission on Continuing Professional Development that the AAFP increase involvement in activities addressing Risk Evaluation and Mitigation Strategies (REMS) requirements, potential concerns of mandatory continuing medical education (CME), and the public health problem of pain management.

B2012, May 1-3, p. 6.

The Board engaged in a discussion regarding the Academy's position against mandatory CME for opioid prescribing. The discussion included information on the Academy's involvement with the President's Initiative on Prescription Drug Abuse and Heroin Use, the specific CME requirements by state medical boards, the 2012 Board-approved Position Paper on Pain Management and Opioid Abuse; and a report to the Board in February 2015 on Academy activities in this area. The Board agreed to maintain the current policy against mandatory CME and instead focus on improving our message to governmental agencies about our many efforts to inform and educate our members in this area.

B2015, December 10-11, p. 4.

RESOLUTION NO. 508 (Washington C)

Transgender Use of Public Facilities

Introduced by the Washington Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, Transgender people experience worse health compared with cisgender people due to avoidance of care, stress from discrimination and alienation[1], and higher rates of sexual and physical violence[2], and

WHEREAS, gender dysphoria intensifies over time and, when inadequately treated, can lead to clinically significant psychological distress, dysfunction, debilitating depression, self-surgery, and suicidality[3], and

WHEREAS, in order to adequately treat gender dysphoria[3,4], transgender women must live fully as females and transgender men must live fully as males in society, and

WHEREAS, all people share the real human need for access to safe restroom facilities[1], and

WHEREAS, being required to use a public facility that does not correspond with gender identity is a health issue that negatively affects transgender people by increasing their risk of experiencing sexual, verbal and physical harassment and violence, and

WHEREAS, inability to access restroom facilities and avoidance of restroom use is a health issue that has been shown to lead to health problems including dehydration, kidney infections and urinary tract infections[1], and

WHEREAS, nine bills have been introduced in various states across the United States in January 2016 dictating the use of public facilities, such as restrooms and locker rooms, and

WHEREASE, these bills require people to use public facilities that correspond with their biological sex identified at birth and/or chromosomes instead of their gender identity[5], and

WHEREAS, proposed legislation effectively makes it illegal for transgender people to live as the gender with which they identify, which, as described above, has significant health implications and furthermore sends the message to transgender people that they are unwanted, misunderstood, and unprotected, and

WHEREAS, current federal nondiscrimination laws covering public facilities cover only race, color, religion, national origin and disability, and does not prohibit discrimination based on sex, gender identity or sexual orientation in public facilities[6], now, therefore, be it

RESOLVED, That the American Academy of Family Physicians endorse existing state and federal laws that protect people from discrimination based on gender expression and identify, and oppose laws that compromise the safety and health of transgender people by failing to provide this protection, and be it further

RESOLVED, That the American Academy of Family Physicians actively support the ability of transgender people to use the public facilities of the gender with which they identify and actively oppose any legislation which would infringe upon that ability.

(Received 7/22/16)

Fiscal Impact: None

Background:
The AAFP has long-standing policy opposing all discrimination in any form. In addition, the AAFP has recommended curriculum guidelines for family medicine residents published in AAFP Reprint No. 289D, "Lesbian, Gay, Bisexual, Transgender Health," at http://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/Reprint289D_LGBT.pdf. Additional Transgender Health Resources are available at http://www.aafp.org/about/constituencies/resources/glbt/transgender.html.

On May 13, 2016, the U.S. Departments of Education and Justice released joint guidance to help provide educators the information they need to ensure that all students, including transgender students, can attend school in an environment free from discrimination based on sex. The press release with links to additional resources is on http://www.ed.gov/news/press-releases/us-departments-education-and-justice-release-joint-guidance-help-schools-ensure-civil-rights-transgender-students.

The U.S. Supreme Court is expected to consider the issue of transgender bathrooms in its coming term. On August 3, 2016, the Supreme Court issued an order in a case involving a transgender teen, Gavin Grimm, who sued the school board in Gloucester County, VA over a policy requiring students to use bathrooms corresponding with their "biological sex." Grimm's lawsuit alleging civil rights violations was initially dismissed, but in April the U.S. Court of Appeals for the 4th Circuit sided with Grimm, saying his case could move forward.

The U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) published a "Guide to Restroom Access for Transgender Workers" which can be found here: https://www.osha.gov/Publications/OSHA3795.pdf.

The U.S. Equal Employment Opportunity Commission produced a fact sheet on "Bathroom Access Rights for Transgender Employees Under Title VII of the Civil Rights Act of 1964" https://www.eeoc.gov/eeoc/publications/fs-bathroom-access-transgender.cfm

Current Policy:

Patient Discrimination

Prior Congress Action:
None

Prior Board Action:
None

References:

1. Herman, J., The Williams Institute, UCLA School of Law. (2013, June). Gendered Restrooms and Minority Stress: The Public Regulation of Gender and Its Impact on Transgender People's Lives. *Journal of Public Management & Social Policy*. Available at

http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Gendered-Restrooms-and-Minority-Stress-June-2013.pdf
2. Grant, J.M, et al. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, Retrieved from http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.
3. *Manning v. Carter, et al.* 1:14-cv-01609-CKK(D.D.C. 2015)
4. Tobin, H.J. & Jennifer Levi. (2013). Securing Equal Access to Sex-Segregated Facilities for Transgender Students. *Wis. JL Gender, & Soc'y,* 28:301.
5. *LGBT Nondiscrimination and Anti-LGBT Bills Across the Country.* American Civil Liberties Union. Accessed January 25, 2016, https://www.aclu.org/lgbt-nondiscrimination-and-anti-lgbt-bills-across-country.
6. *Public Accommodations*, National Center for Transgender Equality, Retrieved from http://www.transequality.org/know-your-rights/public-accommodations

RESOLUTION NO. 509 (New York F)

Oppose Discrimination Against Transgender People

Introduced by the New York State Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, Transgender people experience worse health, compared with cisgender people due to avoidance of care[1], stress from discrimination and alienation[2], and higher rates of sexual and physical violence[3], and

WHEREAS, "gender dysphoria intensifies over time and, when inadequately treated, can lead to clinically significant psychological distress, dysfunction, debilitating depression, self-surgery, and suicidality[4]," and

WHEREAS, in order to complete the appropriate course of care for gender dysphoria[5,6] and meet the eligibility criteria to receive hormonal and/or surgical care,[7,8] transgender women must live fully as females and transgender men must live fully as males in society, and

WHEREAS, nine bills have been introduced in various states across the U.S. in January 2016 dictating the use of public facilities, such as restrooms and locker rooms, and

WHEREAS, these bills require people to use public facilities that correspond with their biological sex identified at birth and/or chromosomes, instead of their gender identity[9], and

WHEREAS, "all people share the real human need for safe restroom facilities when we go to work, school, and participate in public life[10]," and

WHEREAS, being required to use a public facility that does not correspond with gender identity is a health issue that negatively affects transgender people, increasing the risk of sexual, verbal, and physical harassment and violence, and

WHEREAS, inability to access restroom facilities and avoidance of restroom use is a health issue, and has been shown to lead to problems including dehydration, kidney infections and urinary tract infections[11], and

WHEREAS, restroom restriction legislation effectively makes it illegal for transgender people to live as the gender with which they identify, which has significant health implications, and

WHEREAS, sends the message to transgender people that they are unwanted, unprotected, and to be feared, and

WHEREAS, the American Academy of Family Physician has policy opposing "all discrimination in any form, including but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus, or national origin"[12], but is not explicit on this public restroom issue, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians endorse existing anti-discrimination laws protecting people from discrimination based on gender expression and identity, and be it further

RESOLVED, That the American Academy of Family Physicians oppose restroom restrictive laws that compromise the safety and health of transgender people, and be it further

RESOLVED, That the American Academy of Family Physicians supports adding gender expression and gender identity to the protected categories within federal anti-discrimination laws[13], and be it further

RESOLVED, That the American Academy of Family Physicians oppose laws that compromise the safety and health of transgender people.

(Received 07/30/16)

Fiscal Impact: None

Background

The AAFP has long-standing policy opposing all discrimination in any form. In addition, the AAFP has recommended curriculum guidelines for family medicine residents published in AAFP Reprint No. 289D, "Lesbian, Gay, Bisexual, Transgender Health," which can be found at http://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/Reprint289D_LGBT.pdf. Additional Transgender Health Resources are available at http://www.aafp.org/about/constituencies/resources/glbt/transgender.html.

On May 13, 2016, the U.S. Departments of Education and Justice released joint guidance to help provide educators the information they need to ensure that all students, including transgender students, can attend school in an environment free from discrimination based on sex. The press release with links to additional resources is on http://www.ed.gov/news/press-releases/us-departments-education-and-justice-release-joint-guidance-help-schools-ensure-civil-rights-transgender-students.

The U.S. Supreme Court is expected to consider the issue of transgender bathrooms in its coming term. On August 3, 2016, the Supreme Court issued an order in a case involving a transgender teen, Gavin Grimm, who sued the school board in Gloucester County, VA over a policy requiring students to use bathrooms corresponding with their "biological sex." Grimm's lawsuit alleging civil rights violations was initially dismissed, but in April the U.S. Court of Appeals for the 4th Circuit sided with Grimm, saying his case could move forward.

The U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) published a "Guide to Restroom Access for Transgender Workers" which can be found here: https://www.osha.gov/Publications/OSHA3795.pdf.

The U.S. Equal Employment Opportunity Commission produced a fact sheet on "Bathroom Access Rights for Transgender Employees Under Title VII of the Civil Rights Act of 1964" https://www.eeoc.gov/eeoc/publications/fs-bathroom-access-transgender.cfm

Current Policy

Patient Discrimination

Prior Congress Action
None

Prior Board Action
None

References:

1. Herman, "Gendered Restrooms and Minority Stress: The Public Regulation of Gender and Its Impact on Transgender People's Lives."
2. Ibid.
3. Jaime M. Grant et al., "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey." (Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.
4. *Manning v. Carter, et al.* 1:14-cv-01609-CKK(D.D.C. 2015).
5. *Manning v. Carter, et al.* 1:14-cv-01609-CKK(D.D.C. 2015).
6. Harper Jean Tobin and Jennifer Levi, "Securing Equal Access to Sex-Segregated Facilities for Transgender Students," *Wis. JL Gender, & Soc'y* 28 (2013): 301.
7. E. Coleman et al., "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7," *International Journal of Transgenderism* 13, no. 4 (August 2012): 165–232, doi:10.1080/15532739.2011.700873.
8. Tobin and Levi, "Securing Equal Access to Sex-Segregated Facilities for Transgender Students."
9. "LGBT Nondiscrimination and Anti-LGBT Bills Across the Country," *American Civil Liberties Union*, accessed January 25, 2016, https://www.aclu.org/lgbt-nondiscrimination-and-anti-lgbt-bills-across-country.
10. Jody L Herman, "Gendered Restrooms and Minority Stress: The Public Regulation of Gender and Its Impact on Transgender People's Lives," *Journal of Public Management & Social Policy* 19 (2013): 65–80.
11. Herman, "Gendered Restrooms and Minority Stress: The Public Regulation of Gender and Its Impact on Transgender People's Lives."
12. "Discrimination, Patient," 2015, http://www.aafp.org/about/policies/all/patient-discrimination.html.
13. "Transgender Rights | New York Civil Liberties Union (NYCLU) - American Civil Liberties Union of New York State," accessed March 1, 2016, http://www.nyclu.org/issues/lgbt-rights/transgender-rights.

RESOLUTION NO. 510 (Illinois C)

Study of a National Publicly-Financed, Privately-Delivered Health Care System

Introduced by the Illinois Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, The American Academy of Family Physicians strategic objectives include the advancement of health care for all, and

WHEREAS, the current health care financing system has inherent barriers that can make patient care unaffordable, inequitable, and fragmented, and

WHEREAS, with the growing complexity of insurance coverage, providers are increasingly spending resources on insurance companies' varying billing and documentation requirements, which wastes time and money and contributes to burnout, and

WHEREAS, under a national publicly-financed, privately-delivered (single payer) health care system, all Americans would be fully insured for all medically necessary services, regardless of age, income, employment status, or state of residence, and

WHEREAS, under a single payer system, the percentage of uninsured Americans would be 0%, compared with the current number of 10% (approximately 33 million Americans), and

WHEREAS, under a single payer system, the elimination of administrative waste generated by hospitals and providers doing business with multiple payers, and the elimination of private insurance companies with their high overhead costs, can save taxpayers nearly $400 billion dollars a year, and

WHEREAS, under a single payer system, small and independent physician practices would be free from the hassles of dealing with multiple payers, would not need to rely on collections of copayments and deductibles from patients, and would not need to worry about reduced leverage leading to lower contracted reimbursement rates from insurers, and

WHEREAS, under a single payer system, costs related to physician malpractice (including insurance premiums and damages) may decrease, due to existent coverage for all current and future medical costs related to claims, and improved continuity of patient care, and

WHEREAS, under a single payer system, administrative officials can be held accountable to the public for their actions, whereas in private health insurance, they cannot be, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians consider commissioning a study of the effects of a national publicly-financed, privately-delivered health care system for all Americans, and its potential effects on individual health care access, public health, health care spending, the family physician workforce, and physician burnout.

(Received 08/01/16)

Fiscal Impact: While there is little cost associated with considering whether to commission a study, actually commissioning a study would have a fiscal impact determined by its scope.

Background

The resolution asks the AAFP to consider commissioning a study on a single payer financing system. A single payer health care financing system is one in which the government alone, rather than the government and private insurers, covers all the health care costs for its population. In nations that utilize a single payer system; such as Australia, Britain, or Canada; the government could directly employ health professionals, contract for services from private organizations, or utilize a mix of private and public providers.

The single payer system has been considered in the years preceding and following the enactment of the *Affordable Care Act* (ACA). However, none of those proposals have received the bipartisan support necessary to progress. Furthermore, no presidential nominee from either major party has made a single payer system a policy priority.

In the 114th Congress, the *Expanded & Improved Medicare For All Act* (HR 676) was introduced by Rep. John Conyers, Jr. (D-MI) to establish Medicare for All to provide all individuals residing in the United States and U.S. territories with free health care that includes all medically necessary care, such as primary care and prevention, dietary and nutritional therapies, prescription drugs, emergency care, long-term care, mental health services, dental services, and vision care. In addition, the *American Health Security Act (*HR 1200) was introduced by Rep. Jim McDermott (D-WA) who will be retiring at the end of the year. Currently, neither bill has progressed beyond the introduction stage.

In the states, there have been a number of legislative proposals on a single payer. A number of states including Illinois, Maine, Massachusetts, Missouri, New Hampshire, New York, Ohio, Rhode Island, South Carolina, and Vermont had universal health care proposals introduced in their legislatures this year. Colorado will vote on universal health care this November as it is a ballot initiative. Vermont came the close to enacting single payer dropped its plan in December of 2014 which was the subject of a *New England Journal of Medicine* perspective http://www.nejm.org/doi/full/10.1056/NEJMp1501050#t=article.

In the past, resolutions for the AAFP support of a single payer system have been offered in the Congress of Delegates. The Board of Directors' position and rationale state that this is an issue that has been debated repeatedly; and the issue is affordable health care for all, not eliminating the competitive marketplace of payers. The AAFP policy on Health Care Delivery Systems states, "The AAFP supports universal access to basic health care services for all people. The AAFP believes this goal can be attained with a pluralistic approach to the financing, organization, and delivery of health care. A pluralistic health care delivery approach naturally involves competition based on quality, cost, and service."

Current Policy

Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States

Health Care Delivery Systems

Prior Congress Actions

Resolution No. 508 from the 2011 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) endorse a single payer health insurance plan as a viable solution to the health care access crisis, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) urge the United States Congress to enact the United States National Health Insurance Act (H.R. 676), and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) make available resource materials that constituent chapters and physician members may use to discuss with other physicians and our patients about various systems of health care management including a single payer health insurance plan.

Please see Pages 272-275 in the 2011 Transactions for details.

Substitute Resolution No. 508 from the 2011 COD (Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) make available to constituent chapters and physician members educational resource materials about various health care systems including single payer health care plans.

Please see Pages 272-275 in the 2011 Transactions for details.
Please see Page 176 in the 2012 Transactions for follow-up details.

Resolution No. 507 from the 2014 COD (Reaffirmed as Current Policy):

RESOLVED, That the American Academy of Family Physicians actively participate in national deliberations and discussions pertaining to single payer financing systems for health care reform.

Please see Page 367 in the 2014 Transactions for details.

Prior Board Actions

Approval of referring an amended recommendation back to the Commission on Governmental Advocacy for further work that the AAFP add a list of resources to its web pages that describe ~~alternative~~ health plans, including single payer plans.

B2012, May 1-3, p. 15.

Approval of a recommendation from the Commission on Governmental Advocacy that the AAFP add a list of resources to its webpages that describe alternative health plans, including single payer plans.

B2012, July 18-21, p. 20.

RESOLUTION NO. 511 (New York B)

Physician Protection under Single Payer

Introduced by the New York State Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, The membership of the American Academy of Family Physicians (AAFP) is comprised of both employed physicians and physicians in private practice, and

WHEREAS, physicians in private practice are further divided into those in solo practice, small groups, and large groups, and

WHEREAS, the AAFP must recognize the profound differences in the nature of the varied practice situations in order to serve the needs of all its members, and

WHEREAS, the AAFP favors single payer in order to guarantee access of patients to health care with administrative simplicity and simultaneously needs to protect the varied interests of its membership, now, therefore, be it

RESOLVED, That American Academy of Family Physicians only support single payer models that include protections for practicing physicians from unilateral decisions by the payer.

(Received 07/30/16)

Fiscal Impact: None

Background

The resolution asks the AAFP only support single payer models that include protections for practicing physicians from unilateral decisions by the payer. A single payer health care financing system is one in which the government alone, rather than the government and private insurers, covers all the health care costs for its population. In nations that utilize a single payer system; such as Australia, Britain, or Canada; the government could directly employ health professionals, contract for services from private organizations, or utilize a mix of private and public providers.

The single payer system has been considered in the years preceding and following the enactment of the *Affordable Care Act* (ACA). However, none of those proposals have received the bipartisan support necessary to progress. Furthermore, no presidential nominee from either major party has made a single payer system a policy priority.

In the 114th Congress, the *Expanded & Improved Medicare For All Act* (HR 676) was introduced by Rep. John Conyers, Jr. (D-MI) to establish Medicare for All to provide all individuals residing in the United States and U.S. territories with free health care that includes all medically necessary care, such as primary care and prevention, dietary and nutritional therapies, prescription drugs, emergency care, long-term care, mental health services, dental services, and vision care. In addition, the *American Health Security Act* (HR 1200) was introduced by Rep. Jim McDermott (D-WA) who will be retiring at the end of the year. Currently, neither bill has progressed beyond the introduction stage.

In the states, there have been a number of legislative proposals on single payer. A number of states including Illinois, Maine, Massachusetts, Missouri, New Hampshire, New York, Ohio, Rhode Island, South Carolina, and Vermont had universal health care proposals introduced in their legislatures this year. Colorado will vote on universal health care this November as a ballot initiative. Vermont came the close to enacting single payer but dropped it in December of 2014 as reported in a New England Journal of Medicine perspective http://www.nejm.org/doi/full/10.1056/NEJMp1501050#t=article.

In the past, resolutions for the AAFP support of a single payer system have been offered in the Congress of Delegates. The Board of Directors' position and rationale state that this is an issue that has been debated repeatedly; and the issue is affordable health care for all, not eliminating the competitive marketplace of payers. The AAFP policy on Health Care Delivery Systems states, "The AAFP supports universal access to basic health care services for all people. The AAFP believes this goal can be attained with a pluralistic approach to the financing, organization, and delivery of health care. A pluralistic health care delivery approach naturally involves competition based on quality, cost, and service."

Current Policy

Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States

Health Care Delivery Systems

Prior Congress Actions

Resolution No. 508 from the 2011 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) endorse a single payer health insurance plan as a viable solution to the health care access crisis, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) urge the United States Congress to enact the United States National Health Insurance Act (H.R. 676), and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) make available resource materials that constituent chapters and physician members may use to discuss with other physicians and our patients about various systems of health care management including a single payer health insurance plan.

Please see Pages 272-275 in the 2011 Transactions for details.

Substitute Resolution No. 508 from the 2011 COD (Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) make available to constituent chapters and physician members educational resource materials about various health care systems including single payer health care plans.

Please see Pages 272-275 in the 2011 Transactions for details.
Please see Page 176 in the 2012 Transactions for follow-up details.

Resolution No. 507 from the 2014 COD (Reaffirmed as Current Policy):

RESOLVED, That the American Academy of Family Physicians actively participate in national deliberations and discussions pertaining to single payer financing systems for health care reform.

Please see Page 367 in the 2014 Transactions for details.

Resolution No. 508 from the 2014 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians support universal access to comprehensive, affordable, high-quality health care through a single payer system.

Please see Pages 353-354 in the 2014 Transactions for details.

Prior Board Actions

Approval of referring an amended recommendation back to the Commission on Governmental Advocacy for further work that the AAFP add a list of resources to its web pages that describe ~~alternative~~ health plans, including single payer plans.
B2012, May 1-3, p. 15.

Approval of a recommendation from the Commission on Governmental Advocacy that the AAFP add a list of resources to its webpages that describe alternative health plans, including single payer plans.
B2012, July 18-21, p. 20.

RESOLUTION NO. 512 (New York I)

Single Payer

Introduced by the New York State Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, Access to medical care in increasingly threatened by the fact that 29 million people in the United States are without health insurance, and

WHEREAS, the current administrative overhead of health care is increasingly expensive because of our multiple-payer system with its multiple rules, forms, and procedures, costing an estimated 17-19% of the total health care dollar in contrast to only 10% in Canada and some European countries, and

WHEREAS, the cost of health care is rising at a pace about double that of inflation, to an estimated sum of $3.4 trillion nationally in 2016 and $5.4 trillion in 2024, with a per capita spending that is the highest in the world, and

WHEREAS, such rising costs threaten to undermine further access to health care services, and

WHEREAS, the current approach to financing health care is largely tax-based with Medicaid, Medicare, state and local government funding about 60% of health care and the remainder being employer-financed insurance, which places an unfair burden on employers and employees, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate for a single payer health care system in the United States that is financed through taxes to replace the current multiple-payer approach, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for a national single-payer health care system whose rates are set and administrative processes determined by bilateral negotiations between the payer and provider groups, including adequate reimbursement to physicians and eliminating wasteful administrative processes to ensure that physicians are financially stable and able to deliver quality health care.

(Received 07/30/16)

Fiscal Impact: None

Background

The resolution asks the AAFP to advocate for a national single payer health care system. A single payer health care financing system is one in which the government alone, rather than the government and private insurers, covers all the health care costs for its population. In nations that utilize a single payer system; such as Australia, Britain, or Canada; the government could directly employ health professionals, contract for services from private organizations, or utilize a mix of private and public providers.

The single payer system has been considered in the years preceding and following the enactment of the *Affordable Care Act* (ACA). However, none of those proposals have received the bipartisan support necessary to progress. Furthermore, no presidential nominee from either major party has made a single payer system a policy priority.

In the 114th Congress, the *Expanded & Improved Medicare For All Act* (HR 676) was introduced by Rep. John Conyers, Jr. (D-MI) to establish Medicare for All to provide all individuals residing in the United States and U.S. territories with free health care that includes all medically necessary care, such as primary care and prevention, dietary and nutritional therapies, prescription drugs, emergency care, long-term care, mental health services, dental services, and vision care. In addition, the *American Health Security Act (*HR 1200) was introduced by Rep. Jim McDermott (D-WA) who will be retiring at the end of the year. Currently, neither bill has progressed beyond the introduction stage.

In the states, there have been a number of legislative proposals on a single payer. A number of states including Illinois, Maine, Massachusetts, Missouri, New Hampshire, New York, Ohio, Rhode Island, South Carolina, and Vermont had universal health care proposals introduced in their legislatures this year. Colorado will vote on universal health care this November as it is a ballot initiative. Vermont came the close to enacting single payer but dropped it in December 2014 as reported in a New England Journal of Medicine perspective http://www.nejm.org/doi/full/10.1056/NEJMp1501050#t=article.

In the past, resolutions for the AAFP support of a single payer system have been offered in the Congress of Delegates. The Board of Directors' position and rationale state that this is an issue that has been debated repeatedly; and the issue is affordable health care for all, not eliminating the competitive marketplace of payers. The AAFP policy on Health Care Delivery Systems states, "The AAFP supports universal access to basic health care services for all people. The AAFP believes this goal can be attained with a pluralistic approach to the financing, organization, and delivery of health care. A pluralistic health care delivery approach naturally involves competition based on quality, cost, and service." (Emphasis added)

Current Policy

Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States

Health Care Delivery Systems

Prior Congress Actions

Resolution No. 508 from the 2011 COD (Not Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) endorse a single payer health insurance plan as a viable solution to the health care access crisis, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) urge the United States Congress to enact the United States National Health Insurance Act (H.R. 676), and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) make available resource materials that constituent chapters and physician members may use to discuss with other physicians and our patients about various systems of health care management including a single payer health insurance plan.

Please see Pages 272-275 in the 2011 Transactions for details.

Substitute Resolution No. 508 from the 2011 COD (Adopted):

RESOLVED, That the American Academy of Family Physicians (AAFP) make available to constituent chapters and physician members educational resource materials about various health care systems including single payer health care plans.

Please see Pages 272-275 in the 2011 Transactions for details.
Please see Page 176 in the 2012 Transactions for follow-up details.

Resolution No. 507 from the 2014 COD (Reaffirmed as Current Policy):

RESOLVED, That the American Academy of Family Physicians actively participate in national deliberations and discussions pertaining to single payer financing systems for health care reform.

Please see Page 367 in the 2014 Transactions for details.

Prior Board Actions

Approval of referring an amended recommendation back to the Commission on Governmental Advocacy for further work that the AAFP add a list of resources to its web pages that describe ~~alternative~~ health plans, including single payer plans.
B2012, May 1-3, p. 15.

Approval of a recommendation from the Commission on Governmental Advocacy that the AAFP add a list of resources to its webpages that describe alternative health plans, including single payer plans.
B2012, July 18-21, p. 20.

RESOLUTION NO. 513 (New York C)

Make the Minimum Wage a Living Wage

Introduced by the New York State Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, Poverty is a major social determinant of health as recognized by the American Academy of Family Physicians (AAFP), and

WHEREAS, the current federal minimum wage of $7.25 is worth roughly 25 percent less than the minimum wage in 1968, and

WHEREAS, a person earning the current minimum wage 40 hours per week for 50 weeks of the year grosses $14,500 in earnings, and

WHEREAS, the federal poverty level for a family of two in 2015 is $15,930, and for a family of four is $24,250, and

WHEREAS, the current inflation-adjusted federal minimum wage would be $10.90 per hour, and

WHEREAS, the current minimum wage disproportionately affects those that are white, young, and women, and

WHEREAS, Americans in poverty are more likely than those who are not to struggle with a wide array of chronic health problems – including depression, obesity, asthma, diabetes, hypertension, and cardiac disease, and

WHEREAS, minimum wage increases have been shown to not have adverse effects on employment, and

WHEREAS, the American Public Health Association has strongly supported minimum wage increases, including through a policy statement stressing that “federal, state, and local governments should consider and evaluate labor and tax policies to increase income to minimum sustenance levels for the working poor as an explicit public health intervention”, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians support indexing the federal minimum wage to the Federal Poverty Level as a means of decreasing health disparities, and be it further

RESOLVED, That the American Academy of Family Physicians support providing tax relief or other forms of relief for small businesses to reduce their cost of implementing the minimum wage requirement.

(Received 07/30/16)

Fiscal Impact: None

Background

Efforts to raise the federal minimum wage generally split along party lines, with Democrats in support of raising it and Republicans opposed. Many of the arguments in support of raising the minimum wage are expressed in the "whereas" clauses above; the principal argument advanced against it is that it will discourage employers from creating new jobs and hiring new workers. Another argument among Congressional Republicans is that the federal minimum wage is merely a national floor; the states and municipalities can and do set state and local minimum wages that often exceed the federal minimum wage (for example the minimum wage in the City of San Francisco is $13.00 per hour), and those states and local governments should act to best meet the unique needs of their communities, rather than the U.S. Congress.

Raising the Federal Minimum Wage and Indexing it to Inflation

The federal minimum wage is $7.25 per hour. In 2007, Congress enacted the *Fair Minimum Wage Act of 2007*, which raised the federal minimum wage from $5.15 per hour to $7.25 per hour, in stages. This was one of the first legislative acts of the newly-elected Democratic Congress, and was signed into law by President Bush.

In 2014, the Democratic Senate sought to bring to a floor vote the *Minimum Wage Fairness Act* (S 2223), sponsored by Sen. Tom Harkin (D-IA), which failed to clear the 60-vote minimum threshold to end debate and reach a vote on the merits. S 2223 would have increased the current federal minimum wage of $7.25 to $10.10 over a 30-month window, with annual increases in inflation afterward. The bill failed to advance by a vote of 54-42. Only one Republican (Sen. Bob Corker of Tennessee) voted to end debate and put the bill to a vote. The bill was strongly supported by the Obama Administration.

Another prominent proposal in the current Congress is the *Pay Workers a Living Wage Act*, introduced in the current Congress by Sen. Bernie Sanders (I-VT) as S 1832 and Reps. Raul Grijalva (D-AZ) and Keith Ellison (D-MN) as HR 3164. This bill would raise the federal minimum wage to $15.00 by 2020, and then index the minimum wage to inflation. This bill has more modest support, even among Democrats (5 Senate co-sponsors and 55 House co-sponsors).

The Obama Administration has issued executive orders that advance the cause of raising the minimum wage, e.g. by raising the minimum wage for certain federal contractors. President Obama signed an executive order in early 2014 that accomplished the policy in the Harkin bill (increase minimum wage from $7.25 to $10.10 over three years and index to inflation thereafter) for some 2 million employees of government contractors. The U.S. Department of Labor has also launched a web page dedicated to the topic of wage equity.

Tax Relief for Small Businesses to Offset Higher Minimum Wage

Although there is no specific legislative proposal designed to reduce the cost to small business of implementing a higher minimum wage requirement, certain tools in the tax code could be used to accomplish this purpose. For example, as an economic stimulus during the post-financial crisis economic recovery, Congress enacted a "payroll tax holiday" that lasted for two years. The employee portion of the Social Security payroll tax is 6.2 percent of individual earnings, up to the taxable maximum of $110,100. From January 1, 2011 through Jan. 1, 2013, Congress reduced that from 6.2 percent to 4.2 percent. This resulted in a take-home pay hike for most American workers. The employer share of 6.2 percent remained in place during that time. While controversial in some respects—because the payroll tax is used to fund the Social Security system—this is an example of the type of tool that could be used to decrease the tax burden on an employer in order to help them more easily pay a higher minimum wage.

Current Policy

Poverty and Health: The Family Medicine Perspective

Prior Congress Actions

None

Prior Board Actions

Consideration of a recommendation from the Commission on Membership and Member Services referring the NCSC Resolution No. 3008 "Raising the Minimum Wage" to the Board of Directors. This resolution will be included on the agenda for the Board's July meeting for consideration.

BC1:12014, June 26, p. 1.

Joint referral of the 2014 NCSC Resolution No. 3008, "Raising the Minimum Wage" to the Commission on Governmental Advocacy and the Commission on Health of the Public and Science.

B2014, July 30-August 1, p. 26.

Approval of a recommendation from the Subcommittee on Resolution and Policy Review and upon a motion duly made, seconded and carried, the Board referred 2014 National Conference of Medical Students Resolution No. S1-405, "Support for Increasing the Minimum Wage" to the Commissions on Governmental Advocacy and Health of the Public and Science.

B2015, February 25-27, p. 7.

Approval of a recommendation from the Commission of Health of the Public and Science that the new position paper titled, "Poverty and Health – The Family Medicine Perspective" in response to 2014 NCSM Resolution No. S1-405."Support for Increasing the Minimum Wage" and 2014 NCSC Resolution No. 3008 "Raising the Minimum Wage."

B2015, July 22-*25*, p. 13 and Attachment 2.

RESOLUTION NO. 514 (New York H)

Health Coverage for Nutritional Products for Inborn Errors of Metabolism

Introduced by the New York State Chapter

Referred to the Reference Committee on Advocacy

WHEREAS, Individuals with inborn errors of metabolism require specialized nutrition for health and survival, and

WHEREAS, this nutrition is of necessity manufactured and is not a natural food, and

WHEREAS, these products are expensive to produce and not in high demand, and are therefore costly, and

WHEREAS, these products are not considered medication nor considered an essential health benefit under the Patient Protection and Affordable Care Act, and

WHEREAS, Medicaid provides insurance coverage for these products in some states, but many private insurer and self-funded insurance plans do not, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate with the U.S. Department of Health and Human Services and members of U.S. Congress for the classification of specialized nutritional products for the treatment of inborn errors of metabolism as an essential health benefit under the Patient Protection and Affordable Care Act for individuals of all ages diagnosed with these conditions, and that they be categorized as preventive measures not subject to cost sharing.

(Received 07/30/16)

Fiscal Impact: None

Background

The *Affordable Care Act* requires that non-grandfathered health plans in the individual and small group markets cover essential health benefits (EHB), which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

Through notice of proposed rulemaking with public comment, the Department of Health and Human Services (HHS) defines the essential health benefits within these 10 categories. The *ACA* requires HHS to ensure that such essential health benefits a) reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category; b) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life; b) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; and d) ensure that health benefits established as essential not be subject to denial to individuals against their wishes

on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.

Although genetic disorders are often considered to be "rare", collectively they are common. Birth defects are the most common cause of death in the first year of life in the United States, and each year more than 3 million children under the age of 5 years die from a birth defect. The economic impact is large, as each child with a genetic disorder is estimated to cost the healthcare system a total of $5 million dollars over their lifetime. With the President's Precision Medicine Initiative, and the continued drop in costs of DNA sequencing, the number of individuals in the United States diagnosed with genetic disease is likely to rise over the next decade.

A subset of these individuals with genetic disorders have "inborn errors of metabolism," in which the genetic defect leads to a problem with the way the body processes biomolecules, such as carbohydrates, fats, and proteins. Some of these inborn errors of metabolism have highly effective dietary treatments. For these patients, these specialized nutritional products are not only lifesaving; they also lead to improved cognitive and developmental outcomes for these children.

It has long been the mission of federally mandated state-run newborn screening programs to identify children with inborn errors of metabolism prior to the onset of damaging symptoms, so that they can benefit from these nutritional products. These specialized nutritional products provide a life-changing and life-saving treatment for these children.

Current Policy

Healthy Foods

Prior Congress Actions
None

Prior Board Actions
None

RESOLUTION NO. 515 (Co-Sponsored I)

National Prescription Drug Monitoring Program

Introduced by the Missouri, Arkansas, Kansas and Tennessee Chapters

Referred to the Reference Committee on Advocacy

WHEREAS, Each day, 78 (2014) people die from an overdose of opioids and other prescription drugs in the United States[1], and

WHEREAS, opioid overdoses have exponentially increased in the last 10 years, and

WHEREAS, Missouri has the seventh highest overdose rate in the country[2], and

WHEREAS, Missouri shares eight border states – the most in the country – and has become a safe haven for doctor shoppers, and

WHEREAS, Missouri is the only state[3] without a prescription drug monitoring program, and

WHEREAS, St. Louis City and County have passed and are implementing local prescription drug monitoring programs and other Missouri communities are actively pursuing the same, and

WHEREAS, a prescription drug monitoring program is a critical tool for reducing the abuse, addiction, and diversion of opioids and other prescription drugs[4], and

WHEREAS, a prescription drug monitoring program supports access to legitimate medical use of controlled substances, and

WHEREAS, Missouri legislators, law enforcement, physicians, pharmacists, prevention and substance abuse groups, health care organizations, and citizens have supported the passage of a prescription drug monitoring program since 2007, and

WHEREAS, patient privacy is a critical provision of a successful program, and

WHEREAS, prescription drug monitoring programs in other states[5] have been shown to reduce abuse, save lives, and protect our communities, and

WHEREAS, the American Academy of Family Physicians position paper on "Pain Management and Opioid Abuse: A Public Health Concern"[6], urges all states to implement prescription drug monitoring programs and the interstate exchange of registry information as called for under the National All Schedules Prescription Electronic Reporting (NASPER) Act of 2005, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate for interoperability between prescription drug monitoring programs that will ensure secure data transport between systems and maintain the utmost highest level of privacy for patients' history of controlled substance prescriptions, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for creating a secure national database for physicians and pharmacists to maintain and review information about patients who have been prescribed drugs that have a high potential for being abused or misused, such as opioid agonists, benzodiazepines, sedative hypnotics, amphetamines and similar agents, and cannabinoids.

(Received 08/11/16)

Fiscal Impact: None

Background

The current policy for AAFP challenges its members at the physician level to appropriately use prescription drug monitoring programs (PDMPs). The AAFP supports implementation and use of PDMPs and greater physician input into pain management regulation and legislation. At the advocacy level AAFP policy states that they will work with state and national partners to improve the functionality, utility, and interoperability of PDMPs and develop best practices for their use and implementation.

While there is currently no federal legislation to call for a national PDMP database, Congress has taken steps to create and strengthen prescription drug monitoring programs. On August 11, 2005, President George W. Bush signed into law the *National All Schedules Prescription Electronic Reporting* (NASPER) Act. NASPER authorized state grants administered by the U.S. Health and Human Services Department (HHS) to combat prescription drug abuse through a prescription monitoring program. Since 2002, the Hal Rogers Prescription Monitoring Program, named for Rep. Harold Rogers (R-KY) who chairs the House Appropriations Committee, has provided grants managed by the U.S. Department of Justice to states and territories set up and improve PDMPs.

On July 22, 2016, President Obama signed into law the *Comprehensive Addiction and Recovery Act* (CARA). This is the first major federal addiction legislation in 40 years, and the most comprehensive effort undertaken to address the opioid epidemic, encompassing all six pillars necessary for such a coordinated response—prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal. CARA reauthorized the funding for NASPER for states to improve or maintain a PDMP.

CARA requires the HHS Secretary to maintain, supplement or revise minimum requirements for criteria to be used by States for applying the latest advances in health information technology in order to incorporate prescription drug monitoring program data directly in the workflow of prescribers and dispensers to ensure timely access to patients' controlled prescription drug history. CARA also created a comprehensive opioid abuse grant program which makes grants available to states to provide services primarily related to opioid abuse. A qualifier for a state to receive a grant is for a state to develop, implement, or expand a prescription drug monitoring program to collect and analyze data related to the prescribing of schedules II, III, and IV controlled substances through a centralized database administered by an authorized State agency, which includes tracking the dispensation of such substances, and providing for interoperability and data sharing with each other such program in each other State, and with any interstate entity that shares information between such programs.

While CARA authorizes over $181 million each year in new funding to fight the opioid epidemic, monies must be appropriated annually in order for it to be distributed in accordance with the law. Congress has not yet finalized fiscal year 2017 appropriations bills.

At the state level, 49 states and the District of Columbia have PDMPs. Missouri is the only state which does not have one. Additionally, more than 30 states are members of the National Association of Boards of Pharmacy (NABP) PMP InterConnect. NABP PMP InterConnect facilitates the transfer of prescription monitoring program data across state lines to authorized users. Through PMP InterConnect, users of participating PMPs are able to securely exchange prescription data between certain states. If a state is a member, authorized PMP users in that state may gain access to interstate data by logging directly into the state PMP in which they are a registered user. NABP continues to work with other state PMPs to facilitate their participation.

There is little legislative activity regarding state interoperability with PDMPs. Much of the legislation introduced during the 2016 state legislative sessions regarding PDMPs was to mandate their use. According to the National Safety Council, 14 states currently mandate the use of PDMPs. Although there is little legislation addressing this, it does not mean that it is not a concern of the states. 46 Governors have signed the National Governor's Association Compact to Fight Opioid Addiction. With the compact, these Governors commit to build on their efforts to fight opioid addiction by, "integrating data from state prescription drug monitoring programs into electronic health records and requiring PMP use by opioid prescribers and dispensers." Additionally in 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) released PDMP-EHR Integration and Interoperability Expansion Grants as a way to increase interoperability across state lines and improve real-time provider access to data. Nine states were granted funding.

Current Policy

Opioid and Pain Management (Position Paper)

Drugs, Opposition to Mandatory Education for Drug Prescribing

Substance Abuse and Addiction

Prior Congress Actions

Resolution No. 511 from the 2014 COD (Adopted):

RESOLVED, that the American Academy of Family Physicians work with the Office of Diversion Control and/or the Office of the Administrator of the Drug Enforcement Administration to change the current rules for electronic prescribing of controlled substances so that the prescriptions can more easily be sent electronically directly to the pharmacy in a safe and secure manner.

Please see Pages 360-361 in the 2014 Transactions for details.
Please see Substitute Resolution No. 511 on the AAFP website for follow-up details.

Resolution No. 206 from the 2015 COD (Substitute Adopted):

RESOLVED, That the American Academy of Family Physicians request the Veterans Administration participate in any and all state prescription monitoring programs.

Please see Pages 351-352 in the 2015 Transactions for details.
Please see Resolution No. 206 on the AAFP website for follow-up details.

Prior Board Actions

Approval of a recommendation from the Commission on Governmental Advocacy that the AAFP Board of Directors reaffirm as current policy and practice 2013 NCSC Resolution No. 1006, "Controlled Substances Nationwide Tracking System."

B2014, April 29-May 1, p. 42.

Approval of a recommendation from the Commission on Governmental Advocacy that the AAFP send a letter to the U.S. Drug Enforcement Administration (DEA) calling for improving the electronic prescriptions of controlled substances in support of 2014 COD Resolution No. 511, "Electronic Prescription of Controlled Substances" (Adopted)
B2015, April 28-30, p. 79.

Approval of a letter to the DEA in response to 2014 COD Resolution No. 511, "Electronic Prescription of Controlled Substances."
BC1:12015, June 3, p. 1.

Update on activities regarding the opioid prescribing and abuse issues. The AAFP was represented in several meetings and many media inquiries on these issues. Approval of a recommendation to form a Member Advisory Group to assist the staff working group on issues of importance to members in this arena. Additionally, Government Relations staff is monitoring possible legislation at the federal and state levels and will provide appropriate comment and assistance as necessary; Communications and Membership staff is working to engage with Chapters and members on this important area.
B2016, February 24-26, p. 10.

References:

1. Center for Disease Control, 2014 http://www.cdc.gov/drugoverdose/epidemic/index.html
2. Prescription Drug Abuse: Strategies to Stop the Epidemic, Healthy Americans Website, http://healthyamericans.org/reports/drugabuse2013/release.php?stateid=MO
3. Occupational Health and Safety Website, https://ohsonline.com/articles/2012/08/21/missouri-lone-holdout-on-prescription-drug-monitoring.aspx?admgarea=news
4. US Department of Justice, Drug Enforcement Administration, Office of Diversion Control, http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm
5. Center for Disease Control State Successes, http://www.cdc.gov/drugoverdose/policy/successes.html
6. American Academy of Family Physicians Position Paper, http://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/opioid-abuse-position-paper.pdf